

Group policy no. G-23,000	Account
Applicant's name (<i>last, first, middle initial</i>)	Applicant's date of birth (<i>month, day, year</i>)
Applicant's address	Applicant's phone number
If applying for dependent coverage:	
Spouse's name (<i>last, first, middle initial</i>)	Spouse's date of birth (<i>month, day, year</i>)
Name(s) of and date of birth (<i>month, day, year</i>) eligible child(ren)	

HEALTH QUESTIONS

Please personally answer the following questions. If you answer "Yes," to any question, please provide details in REMARKS below. If you are applying for dependent coverage, please answer all questions for your eligible dependents.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Applicant's height _____ Weight _____ Spouse's height _____ Weight _____
Have you or your dependents gained or lost 10 or more pounds during the past 12 months?
If "Yes," how much <input type="checkbox"/> Gained _____ <input type="checkbox"/> Lost _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you or your dependents within the past 5 years: | | |
| a) Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Used any illegal drug? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 5 years, have you or your dependents ever had, been treated for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you or your dependents ever had, been medically diagnosed, treated, or been advised to seek treatment for: arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; acquired immune deficiency syndrome (AIDS) within the past 5 years or immune system disorder?
"Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you or your dependents pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

Personal physician _____
NAME
ADDRESS
TELEPHONE NO.

REMARKS AND ADDITIONAL INFORMATION FOR "YES" ANSWERS
If you answered "Yes" to any medical questions above, please provide details below.

Ques. no.	First name	Description of illness, injury or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects	Name and address of attending Physician or Hospital (<i>Include zip.</i>)

Union Security Insurance Company

Mail to: Pensions and Benefits USA Church of the Nazarene 6401 The Paseo Blvd Kansas City MO 64131
T 888.888.4656

IMPORTANT NOTICE TO APPLICANTS—PLEASE READ CAREFULLY

MY SIGNATURE ON THIS FORM SIGNIFIES THAT: (a) I represent that all of the information in this application is complete, correct and true to the best of my knowledge and belief; (b) I understand that I may be required to furnish, at my own expense, additional proof of good health satisfactory to Union Security Insurance Company.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

AUTHORIZATION TO RELEASE INFORMATION: For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, consumer reporting agency, employer or any other organization to give the insurance company or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be insured. I give my permission to the insurance company or its reinsurers to release any information to other life insurance companies as I may come in contact with. I know that I have a right to a copy of this authorization. A photocopy of this authorization will be as valid as the original. This authorization will be valid for two and one half years (in the state of Minnesota 26 months) from the date shown below. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Applicant's signature _____ Date _____

Spouse's signature _____ Date _____

IF SPOUSAL COVERAGE

**NOTICE REGARDING MEDICAL INFORMATION BUREAU
INSURANCE INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION**

To properly underwrite applications and issue insurance policies on an equitable basis, we must obtain information about our proposed insured. The nature of the information we seek includes age, occupation, physical condition, health history, habits, avocations and other personal characteristics. This information will be collected from you and various sources, including health professionals and health facilities. Information regarding factors affecting insurability will be treated as confidential.

In addition, we may obtain an investigative consumer report from an insurance support organization. If a report is prepared, upon request to your agent, you have the right to be personally interviewed in connection with the investigation. Also, upon proper request to Union Security Insurance Company, you may obtain a copy of the report.

Further, we or our reinsurers may obtain a report from and make a report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another bureau member for life or health coverage, or a claim for benefits is submitted to such a company, the bureau, upon request, will supply information contained in its file.

Upon receipt of a request from you, the bureau will arrange disclosure of the information in its file. If the accuracy of the information is questioned, you may request that corrections be made by following the procedures set forth in the Fair Credit Reporting Act. The address of the Bureau's Information Office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112 (telephone 617.426.3660).

The information which we collect may, under certain circumstances, be disclosed to third parties without your specific authorization. However, be assured that disclosure will be strictly limited to that which is reasonably required. This authorization is not governed by HIPAA, however, when necessary, you may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding.

If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Senior Vice-President, Underwriting and Administration, 2323 Grand Boulevard, Kansas City, Missouri 64108.